LOUISIANA PATIENT'S COMPENSATION FUND

STRATEGIC PLAN

FISCAL YEAR 2005-06 THROUGH FISCAL YEAR 2009-10

VISION STATEMENT

Act 817 of the 1975 legislature created the Patient's Compensation Fund (PCF). The PCF has always labored to attain the position where it functions in a manner that combines quality claims administration with stable surcharge rates. From 1975 until 1990, health care providers received the benefit of low PCF surcharge rates. Unfortunately, however, claims administration, and in particular the setting of adequate case reserves, was practically nonexistent.

Since the establishment of the Patient's Compensation Fund Oversight Board (Board) in 1990, claims administration has vastly improved. In order to overcome 15 years of inadequate surcharge collections, however, health care providers have been faced with annual, and in some instances, substantial rate increases. Notwithstanding those rate increases, for the past several years, the PCF/Board has been the subject of findings by the legislative auditor which include the failure to maintain statutorily mandated assets. The statute was amended in the 2004 Regular Session of Legislature to reflect a more accurate asset goal, closer in line with acceptable industry standards. Outside the argument of whether the particular statutory requirements are reasonable or not, it is clear that the original intent behind the creation of the PCF must not continue to withstand significant deficiencies.

The PCF must continue to improve communication with agencies, brokers, insurance companies, and providers in order to share ideas and to improve the efficiency of the Fund and its procedures including the state statute and rules/regulations. Additionally, the Fund must focus on general statistics relative to essential and fundamental trends.

It is the vision of the PCF Oversight Board to progressively close the gap between outstanding liabilities and current assets, without relying exclusively on annual rate increases, so that private health care providers in Louisiana can have stable and reasonable surcharge rates that are sufficient to fairly compensate legitimate victims of medical malpractice. Financial stability serves to make PCF more attractive to medical malpractice insurers thereby drawing more companies to Louisiana to write medical malpractice policies. Increased competition among these companies leads to more competitive and affordable rates for Louisiana health care providers. This, in turn, creates a positive atmosphere toward encouraging health care providers to continue to practice in this state and in attracting new providers to Louisiana.

MISSION STATEMENT

It is the mission of the Patient's Compensation Fund Oversight Board (Board) to administer, manage, operate, and coordinate the defense of the Patient's Compensation Fund (PCF) in a manner that will timely and efficiently meet the needs and interests of those groups for whom the PCF was created to serve---Louisiana health care providers, legitimate victims of medical malpractice, and the citizens of the state.

The PCF was created by Act 817 of the 1975 legislature in order to guarantee that affordable medical malpractice coverage was available to all private health care providers and to provide a certain, stable source of compensation for legitimate victims of malpractice. The PCF and the concurrent limitation on damages that may be awarded against "qualified" health care providers benefits the citizens of the State by providing a corresponding restraint on overall health care costs.

PHILOSOPHY

Medical malpractice is a tort (a civil wrong), and such matters are addressed and resolved through negotiated settlements or the adversary system of civil litigation. The Board believes it has the twofold duty to vigorously resist and defend unmeritorious and/or exaggerated claims, while at the same time ensuring that legitimate claims be resolved promptly and fairly.

GOALS

I The Board should strive to maintain surcharge rates that are reasonable and affordable for health care providers but adequate to meet outstanding and projected liabilities.

II The Board must maintain the integrity of the Medical Review Panel Process.

III The Board must stabilize annual total claims payments by properly and aggressively investigating, evaluating, and resolving claims efficiently, timely and fairly.

DUPLICATION OF EFFORT

No other state agency or department performs these tasks or exercises these controls. This unique agency is one of only 14 nationwide to provide and administer this service to its citizens and as such serves as one of, if not **THE** leading benchmark for programs of this type.

Objective I.1

By July 1, 2007, the Board should maintain a PCF surplus equal to at least 30% of case reserves.

Beneficiary: Private health care providers and the victims of medical malpractice will be the primary persons benefiting from this objective because the PCF's financial stability will be secured.

STRATEGY 1.1.1 - Refine internal policies and procedures relative to communicating and interacting with health care providers and their primary carriers, so they will clearly know their duties and obligations for properly enrolling in the PCF and timely remitting surcharge payments.

STRATEGY 1.1.2 – Continue to coordinate with actuarial consultant to refine PCF Rating Manual so classes of providers pay rates commensurate with the risk they pose.

STRATEGY 1.1.3 - Assure that all enrollment correspondence and payments are thoroughly reviewed so that, when applicable, penalties are assessed in accordance with statutory provisions when payments are not on time.

STRATEGY 1.1.4 - Update and refine the experience rating program which allows for the debiting of enrolled health care providers who have poor PCF claims experience.

Louisiana Vision 2020 Link: Objective 3.3 To ensure quality healthcare for every Louisiana citizen.
Children's Budget Link: N/A
Human Resources Policies Beneficial to Women and Children: N/A
Other Links (TANF, Tobacco Settlement, Workforce Development Commission, Others) – N/A

PERFORMANCE INDICATORS:

Input: Annual numbers of enrolled health care providers

Output: Total surcharges collected annually

Outcome: Annual percentage rate increase

Efficiency: Annual number of providers subject to experience rating or penalties

Quality: Total annual experience rating and penalty surcharge collections

Objective II.1

To have achieved by July 1, 2010 that, in 80% of cases filed, the Medical Review Panel opinions are rendered or dismissals obtained within 2 years of the date the complaint was filed.

Beneficiary: All parties including the PCF will benefit from this objective because anytime panel opinions are concluded, it saves time (interest) and money (legal fees) for all parties involved.

STRATEGY 11.1.1 – Maintain statistical medical review panel data and track statutorily mandated timelines by electronic diary system.

STRATEGY 11.1.2 – Update PCF Medical Review Panel procedural and instructional brochure, supplied to individuals chosen as attorney-chairperson, so that all panel members will know their duties as well as all statutory requirements relative to the Medical Review Panel process.

STRATEGY 11.1.3 – Correspond periodically with a selection of those attorneys who chair Medical Review Panels to discuss any problems or possible improvements to areas of the process not specifically addressed in the statute.

Louisiana Vision 2020 Link: Objective 3.3 To ensure quality healthcare for every Louisiana citizen.
Children's Budget Link: N/A
Human Resources Policies Beneficial to Women and Children: N/A
Other Links (TANF, Tobacco Settlement, Workforce Development Commission, Others) – N/A

PERFORMANCE INDICATORS:

Input: Annual number of complaints filed

Output: Annual number of medical review panels closed

Outcome: Annual number of medical review panel opinions rendered

Efficiency: Annual number of medical review panels closed

Quality: Annual number of medical review panels closed within 2 years of filing

Objective III.1

Continue to control total claims payments so that they do not increase by more than 5% per fiscal year, and control legal expenses so that they do not exceed 6% of total claims payments,

Beneficiary: The PCF and the private health care provider will benefit from this objective because the cost of doing business with the PCF will be primarily stable, therefore, resulting in minimum surcharge increases rather than double digit increases. In controlling legal expenses the PCF will make available more aggregate payments directly to victims of medical malpractice and less aggregate payments in legal expenses.

STRATEGY 111.1.1 - In order to set appropriate reserves, continually strive to build a closer working relationship with primary carriers and self-insured's in order to know as early as possible if a claim has the potential to impact the PCF's layer of coverage. Arrange annual or semiannual meetings with representatives of these entities to discuss problems and possible solutions as well as providing accurate, up-to-date information to these individuals via the PCF web site.

STRATEGY 111.1.2 - In cases with potential to exposure to PCF's layer of coverage, maintain a diary system so that the adequacies of reserves are reviewed at least every 180 days.

STRATEGY 111.1.3 - Whenever possible, attempt joint settlements with primary carrier or self-insured so that PCF can negotiate while liability is still an issue.

STRATEGY 111.1.4 - Closely monitor and evaluate all payment requests on claims involving future medical payments to assure that expenses are reasonable, necessary and related. When indicated, utilize professional audits of medical bills. Continue to utilize a "fee schedule" for these expenses similar to those used in Department of Labor's Worker's Compensation.

STRATEGY 111.1.5 – Limit reliance on defense counsel to those matters that include but are not limited to claims that the PCF staff is unable to reach a settlement after fair but aggressive negotiations, matters involving statutory interpretations, and judgments that need to be appealed.

STRATEGY 111. 1.6 - When assigning a case to defense attorneys, make sure to be very specific in their pertinent contracts as to specific tasks to be performed and services to be provided, thoroughly review attorney's itemized charges and approve if charges are in accordance with these contracts.

STRATEGY 111.1.7 - Annually review and refine, if necessary, written defense counsel guidelines.

Louisiana Vision 2020 Link: Objective 3.3 To ensure quality healthcare for every Louisiana citizen.
Children's Budget Link: N/A
Human Resources Policies Beneficial to Women and Children: N/A
Other Links (TANF, Tobacco Settlement, Workforce Development Commission, Others) – N/A

Objective III.1 (continued)

PERFORMANCE INDICATORS:

Input: Total number of claims opened (assigned to senior adjusters) annually

Output: Total annual reserves
Total annual indemnity reserves
Total annual Future Medical reserves
Total annual legal expense reserves

Outcome: Total annual claims payments
Total annual indemnity payments
Total annual Future Medical payments
Total annual legal expense payments

Efficiency: Annual legal expenses as percentage of total claims payments
Average cost per claim paid
Total number of claims closed annually
Total number of claims settled annually
Average caseload per adjuster

Quality: Annual number of claims closed without any indemnity payment

APPENDIX A

PRINCIPAL CLIENTS AND USERS:

As noted in the Vision Statement and Mission Statement, the Patient's Compensation Fund was established for the benefit of two groups - private health care providers licensed and practicing in the State of Louisiana and legitimate victims of medical malpractice committed by those health care providers.

The health care providers receive:

- Medical malpractice coverage of $400,000, excess of $100,000, plus all related medical expenses at affordable rates.
- A limitation, or statutory "cap", on damages that can be awarded for claims of medical malpractice of $500,000 plus related medical expenses.
- Entitlement to have all claims initially evaluated by a medical review panel of three health care providers before civil litigation can be initiated.
- Competitive and affordable rates brought about due to the financial stability of the Fund and the resultant attraction to malpractice insurance writers.

Legitimate victims of medical malpractice receive:

- A certain and stable source of compensation that will pay up to $400,000, excess of the providers primary source of $100,000, plus all related medical expenses, which includes the cost of custodial care whether it is provided by a business, a private individual, or even a family member.
- Access to better, more affordable health care as a direct result of affordable malpractice insurance drawing a larger pool of health care providers, especially medical specialists, willing to practice in Louisiana.

APPENDIX B

EXTERNAL FACTORS:

1. The Louisiana Judicial System:

Substantive - liberal or excessive court judgments in regard to damages by either judge or jury.

Liberal interpretations of the facts of a case as to the question of a provider's liability.

Procedural - various aspects of the malpractice statute (La R.S. 40:1299.41 et seq.) are constantly scrutinized by the state courts on the question of constitutionality. In Butler v. Flint Goodrich Hospital of Dillard Universily et al. the Louisiana Supreme Court held that:

> "Since the legislature's statutory solution to the medical malpractice problem furthers the states purpose of compensating victims, it is not constitutionally infirm. Overall, the Louisiana Medical Malpractice Act represents a reasonable but imperfect balance between the rights of victims and those of health care providers. It does not violate the state or federal constitutions."

Notwithstanding the above noted decision, the constitutionality of the statute is, and will be, called to question.

2. The Louisiana Insurance Rating Commission (LIRC):

At times in the past the LIRC has refused the Board's request for rate increases that the consulting actuary has determined to be necessary. In fact, this has occurred even when the percentage rate increase sought by the Board was significantly less than actuarially indicated.

3. The Louisiana Legislature:

The legislature could enact amendments to the statute that could make it difficult to achieve the objectives outlined above. Furthermore, the legislature could abolish the PCF and/or the Board.

4. Health Care Providers:

As to risk management, it will be up to health care providers to implement procedures that attempt to reduce the incidence of medical errors. In many instances such procedures entail **additional costs.** Some providers may decide, based upon economic considerations, not to implement such procedures.

APPENDIX C

STATUTORY AUTHORITY:

Act 817 of the 1975 Louisiana legislative session created the Patient's Compensation Fund. The Act is comprised of La. R.S. 40:1299.41 through 40:1299.48. The establishment of the Patient's Compensation Fund is specifically outlined in La. R.S. 40:1299.44.A.

The Patient's Compensation Fund Oversight Board was established by an amendment to Act 817 during the 1990 legislative session, and is found at La. R.S. 40:1299.44.D.

The limitation on damages is found at La. R.S. 40:1299.42.B.

The payment of Future Medical benefits is listed in La. R.S. 40:1299.43.

The Medical Review Panel process is outlined in La. R.S. 40:1299.47.

The PCF Rules and Regulations: as found LAC Title 37-III- Chap.1-19.

APPENDIX D

PROGRAM EVALUATION:

The Patient's Compensation Fund, like most other state agencies, frequently experiences personnel changes and vacancies, including such critically essential positions of Executive Director and Information Technology Technical Support staff.

The Vision Statement was primarily developed as the result of consultation between the Executive Director, the Administrative Director and other key staff members.

Objectives and strategies were the natural outflow of recognition that the Fund's mission could only be met through a combination of the following:

1. Ensure that all applicable surcharges are collected in a timely fashion.

2. Stabilize and hopefully reduce claims expenditures – relative to the number of legitimate claims filed and their respective legal expenses.

3. Train and retain adequate staff to ensure consistent quality and timely results.

Appendix E-1

PERFORMANCE INDICATOR DOCUMENTATION

1. Indicator Name: Annual Number of Enrolled Health Care Providers (GOAL I)

2. Indicator Type: Input

3. Rationale: Represents the number of individuals, groups, and institutions that voluntarily pay the surcharges that comprise the corpus of the PCF.

4. Data Collection Procedure: Self-Insured providers or primary insurance carriers submit all applicable documentation directly to the PCF office. Such documents consist of applications, certificates of insurance, surcharge payments, self-insured security deposits, etc.

5. Frequency and Timing of:
   (a) Collection - documentation is submitted and collected daily
   (b) Reporting - annually for actuarial review

6. Calculation Methodology: any provider who pays an individual surcharge is counted as a single provider. Hospitals, clinics, nursing homes etc. are counted as single providers. Health care providers that are employees of such facilities, but are not required to pay individual surcharges, are included in the total. Physicians, Certified Registered Nurse Anesthetists, Physician's Assistants, Surgical Assistants, Nursing Assistants, and Dentists are required to pay individual surcharges. RN's, LPN's, lab techs, radiology techs, etc. are not required to pay individual surcharges if they are employees of enrolled health care providers.

7. Aggregations or Disaggregating: Total providers are also sub-categorized into:

   - Provider type (physician, hospital, dentist, nursing home, CRNA, All Other, etc.)
   - Physician class (physicians are rated according to 11 classes)
   - Physician specialty (physicians are further categorized as to specialty)

8. PCF/Board is responsible for data collection, data accuracy and integrity, data maintenance and retrieval of integral information.

E-2

1. Indicator Name: Total Annual Surcharges Collected (GOAL I)

2. Indicator Type: Output

3. Rationale: This indicator shows how much is annually paid into the PCF by enrolled health care providers.

4. Data Collection procedure/source:
   All payments are sent directly to the PCF Administrative office and are posted to the PCF database.

5. Frequency and Timing of
   (a) collection - payments are received and are posted daily
   (b) reporting –quarterly or as needed

6. Calculation Methodology:
   How much a provider must pay is based upon current rates published annually in the PCF Rate Manual. PCF personnel make sure the provider has paid the correct surcharge before posting the payment to the database.

7. Aggregations or Disaggregating: Total surcharge payments are sub-categorized by type of provider, physician class, and physician specialty.

9. PCF/Board is responsible for data collection, data accuracy and integrity, data maintenance, and retrieval of integral information

E-3

1. Indicator Name: Annual Percentage Rate Increase/Decrease (GOAL I).

2. Indicator Type: Outcome

3. Rationale: This represents what the Board, based upon recommendations from their consulting actuary, believes is needed to have rates that are both sufficient in regard to outstanding liabilities and reasonably affordable for health care providers.

4. Data Collection Procedure/Source: The Board must annually provide the consulting actuary with surcharge collection data and claims payment data. The actuary performs an analysis of the data and then reports to the Board with recommended rate increases/decreases. The Board then reviews this analysis and votes on proposed rate changes. The Louisiana Insurance Rating Commission (LIRC) must then approve the Board's proposed rate changes.

5. Frequency and Time of:
   (a) Collecting – annually
   (b) Reporting - annually

6. Calculation Methodology: Actuarial Science

7. Aggregations or Disaggregating: Analysis is performed as to total providers but is also subcategorized by provider type and physician class.

8. PCF/Board is responsible for providing the actuary with sound data. The actuary is responsible for professional analysis of the data. The Board is responsible for deciding actual rate change.

9. Limitations: A rate increase may possibly be less than what is actuarially indicated in order to keep rates reasonable and to receive approval from LIRC.

E-4

1. Indicator Name: Annual Number of Providers Paying Experience Rating Assessment or Late Penalties (GOAL I)

2. Indicator Type: Efficiency

3. Rationale: Represents providers who pay additional surcharges based upon poor loss experience or their primary carrier's failure to pay appropriate surcharges on time. These debits make it less likely that good risks will be subsidizing poor risks.

4. Data Collection Procedure/Source: PCF procedures and Act 817 determine providers subject to assessments and PCF staff notifies providers of additional amounts owed.

5. Frequency and Time of:
   (a) Collecting – daily
   (b) Reporting - annually

6. Calculation Methodology: The actuaries have developed experience-rating formulas (published in the Rating Manual) applicable to health care providers, and late surcharge payments are due, according to statute, when payment has not been received within 45 days of the primary carrier's receipt of the surcharge.

7. Aggregations/Disaggregating: As mentioned above, there is separate experience rating formulas for different types of health care providers, such as physicians, dentists, etc. versus hospitals and nursing homes, etc. (Individual versus intuitional)

8. PCF/Board is responsible for data collection, data accuracy and integrity, data maintenance, and retrieval of integral information.

Limitations: A provider is subject to experience rating if they have had at least two incurred losses (currently open or paid within 5 years) that exceed the formula threshold, and the debit cannot exceed 50% of the base surcharge.

E-5

1. Indicator Name: Total Annual Experience Rating Surcharges and Penalties (GOAL I).

2. Indicator Type: Quality

3. Rationale: Represents monies collected into the PCF that are in addition to the base annual surcharge collections. This helps reduce the need for rate increases and makes it less likely that good risks subsidize bad risks.

4. Data Collection Procedure/Source: PCF procedure calls for review of loss history of all providers 90 days prior to renewal. A provider's loss data (if they have had at least 2 incurred losses) is factored into the formula developed by the actuary. If a debit is owed, the provider is notified of the debit percentage that must be paid in addition to the base surcharge (up to a maximum 50% debit). For late payments, the statute provides that the Board shall determine a penalty not to exceed 12% of the base surcharge.

5. Frequency and Time of:
   (a) Collecting – annually
   (b) Reporting - annually

6. Calculation Methodology:

   For experience rating, if a provider's loss history shows total incurred losses (must be based on more than one claim) a certain range, the provider can be subject to debits in increments of 10% up to a maximum of 50%. For late payments, statute provides that the Board shall determine a penalty not to exceed 12% of the base surcharge.

7. Definition of Unclear Terms: Incurred Losses - Loss payments plus loss reserves.

8. Aggregations/Disaggregating: Experience rating formula calculations differ for *individual* categories of health care providers such as physicians, dentists, etc. versus *institutions* such as hospitals, nursing homes, etc.

9. PCF/Board is responsible for determining the assessment of penalties, for the collection of these penalties and for the collection and maintenance of the data.

E-6

1. Indicator Name: Number of Annual Complaints Filed (GOALS II, III)

2. Indicator Type: Input

3. Rationale: Represents the number of complaints filed with the PCF alleging one or more providers committed medical malpractice in the treatment of a particular patient, and requesting the formation of a Medical Review Panel. The annual incidence of alleged malpractice.

4. Data Collection Procedure/Source: Complaints are filed first with the Commissioner of Administration then transmitted to the PCF and all relevant data (claimant name, defendant provider name(s), date of alleged malpractice, date of filing) is entered in the PCF database.

5. Frequency and Time of:

   (a) Collection – daily
   (b) Reporting – quarterly or as necessary.

6. Calculation Methodology: Regardless of the number of defendants, the claim of a patient is listed as a single complaint.

7. Aggregations/Disaggregating: Complaints are sub-categorized by provider type, physician class and physician specialty.

7. PCF/Board is responsible for data collection, data accuracy and integrity, data maintenance, and retrieval of integral information.

E-7

1. Indicator Name: Annual Number of medical review panels closed (GOAL II)

2. Indicator Type: Output

3. Rationale: Represents the number of cases abandoned without necessity of a Medical Review Panel. It gives an indication of the percentage of filed cases that are without merit and/or were not evaluated as to merit prior to filing.

4. Data Collection Procedure/Source: Notice of dismissals must be sent direct to PCF.

5. Frequency and Time of:
   (a) Collecting – daily
   (b) Reporting – monthly or as needed

6. Calculation Methodology: A claim falls into this category if it is dismissed before a Medical Review Panel renders a decision, whether or not a panel has been formed.

7. PCF/Board is responsible for data collection, data accuracy and integrity, data maintenance, and retrieval of integral information.

E-8

1. Indicator Name: Annual Number of Medical Review Panel Opinions Rendered (GOAL II)

2. Indicator Type: Outcome

3. Rationale: Represents percentage of filed cases that proceed all the way through the Medical Review Panel Process. It also indicates how good a job the PCF and the attorney chairperson are doing in monitoring the cases and making sure they move at a reasonable pace to conclusion.

4. Data Collection Procedure/Source: All opinions are sent to the PCF within 5 days of the signing of the decision by the panelists and are recorded in the PCF database.

5. Frequency and Timing of:

   (a) collection - daily
   (b) reporting – quarterly or as needed

6. Calculation Methodology: In each case an opinion is rendered for each named, qualified defendant with that opinion listing the finding of the panel as to each defendant.

7. Aggregations/Disaggregating: Panel Opinions are categorized by:

- WON - Favorable as to all defendants
- LOST - In favor of the claimant (as to at least one defendant)
- MATERIAL ISSUE OF FACT - There was a material issue of fact not requiring expert medical opinion

7. PCF/Board is responsible for data collection, data accuracy and integrity, data maintenance, and retrieval of integral information.

Note: It should be noted that cooperation from panel chairpersons is a factor in attaining this goal and is, obviously outside the control of this agency.

E-9

1. Indicator Name: Medical Review Panel Files Closed Annually (GOAL II)

2. Indicator Type: Efficiency

3. Rationale: Represents the number of filed complaints in which a panel was formed, rendering an opinion, and ensuring that all corresponding documentation is properly filed. If this number is similar to the number of annual complaints filed minus complaints dismissed, the process is working as intended.

4. Data Collection Procedure/Source: All documentation related to Medical Review Panels is filed directly with the PCF and kept in hard copy files and also in the PCF database.

5. Frequency and Timing of

   (a) Collection - daily
   (b) Reporting – monthly or as needed

6. Calculation Methodology: A panel is not closed until all statutorily required documentation is in the file. It is then closed and recorded as “closed” in the PCF database. Complaints are filed per patient, not per defendant.

7. PCF/Board is responsible for data collection, data accuracy and integrity, data maintenance and retrieval of integral information.

E-10

1. Indicator Name: Annual percentage of Medical Review Panels closed within two years of the filing (Goal II)

2. Indicator Type: Quality

3. Rationale: The Medical Review Panel process was created, in part, to allow the claimant to quickly have the facts of his/her case reviewed by medical professionals who can render an educated opinion as to whether or not malpractice occurred. The expense of litigation is avoided and, hopefully, the case will not be pursued further in court if the panel finds no breach of the standard of care. When one or more of the parties delays the process than the purpose of the panel is defeated and becomes more costly.

4. Date Collection Procedure/Source: Collected internally since the PCF administers and monitors the panel process.

5. Frequency and Timing of
   (a) collection-daily,
   (b) reporting-monthly or as needed

6. Calculation Methodology: Comparing the date the panel renders their opinion or the date the complaint is dismissed with the date the PCF acknowledges that the claim was filed.

7. PCF/Board is responsible for data collection, data accuracy and integrity, data maintenance and retrieval of integral information.

E-11

1. Indicator Name: Total Annual Reserves (GOAL III)

2. Indicator Type: Output

3. Rationale: Represents the total estimated liability of the PCF for all filed claims. A reserve is set by the Claims Department based upon professional judgment of the value of a claim. The reserves are a very important aspect of what the actuaries consider when they analyze data and recommend proposed rate increases/decreases.

4. Data Collection Procedure: The Claims Department sets the reserves on claims and enters that data into the database.

5. Frequency and Time of:
   (a) Collecting – daily
   (b) Reporting – monthly or as needed

6. Calculation Methodology: There are a number of factors that the Claims Department takes into consideration when determining the appropriate reserves for a particular claim such as:

- The nature and extent of the injury
- The age of the claimant
- An evaluation of the likelihood of a finding of liability
- The jurisdiction
- The capabilities of the plaintiff attorney
- **Cooperation from the primary insurer**, which is a **MAJOR** yet **UNCONTROLLABLE** factor
- Judicial interest exposure
- Medical expenses incurred and expected to be incurred.

7. Aggregations/Disaggregating: Total reserves are also categorized as follows:

- Indemnity reserves (settlement or judgments)
- Future Medical reserves (if applicable)
- Legal Expense reserves
- Other Expense reserves

Additionally, total reserves and the above reserve categories are sub-categorized by provider type and physician class and specialty.

8. PCF/Board is responsible for data collection, data accuracy and integrity, data maintenance, and retrieval of integral information.

9. Limitations: A reserve is an estimated, educated guess of the value of a claim based largely on past court cases and settlements. Therefore, it is not an exact science.

At settlement or judgment a determination is made as to whether the claimant will incur necessary and reasonable future medical expenses related to the malpractice.

E-12

1. Indicator Name: Total Annual Claims Payments (GOAL III)

2. Indicator Type: Outcome

3. Rationale: Represents actual claims expenditures. Whereas, reserves are an estimate of future payments, this indicator shows actual loss experience. This represents the other important factor analyzed by actuaries to determining recommended rates. Claims payments tracked for 5 or 10 years can help actuaries to develop trends, which aid in determining reasonable and sufficient rates to meet the needs of future claims.

4. Data Collection Procedure: All claims transactions are performed internally by the in-house Claims Department.

5. Frequency and Timing of
   (a) collection - daily
   (b) reporting - annually

6. Calculation Methodology: The amounts that are paid for indemnity (settlements or judgments) are based upon the same factors noted in the preceding indicator for reserves. In addition, as to judgments, there will be additional sums paid for judicial interest. Expense payments are based upon actual incurred expenses. Future Medical payments, if determined necessary by a court or by agreement between the parties, are paid as incurred.

7. Aggregations/Disaggregating: Payments are categorized as:
   - Indemnity
   - Interest
   - Future Medicals
   - Legal Expenses
   - Other Expenses

8. PCF/Board is responsible for data collection, data accuracy and integrity, data maintenance, and retrieval of integral information.

E-13

1. Indicator Name: Annual Legal Expenses as Percentage of Total Payments (GOAL III).

2. Indicator Type: Efficiency

3. Rationale: This gives an indication of how well the claims department is performing their duties of properly and aggressively investigating, evaluating and resolving claims. It is impossible to avoid legal costs, but adjusters should perform many of the duties that are often delegated to attorneys, such as settlement, negotiation, and evaluation of liability.

4. Data Collection Procedure: Performed internally by in-house claims staff.

5. Frequency and Timing of
   (a) collection - daily
   (b) reporting - annually

6. Calculation Methodology: Simple comparison of Total Claims Expenditures vs. Total Legal expenses.

7. PCF/Board is responsible for data collection, data accuracy and integrity, data maintenance, and retrieval of integral information.

E-14

1. Indicator Name: Claims Closed Annually (GOAL III)

2. Indicator Type: Efficiency

3. Rationale: Annual number of claim files closed. An effective claims department should be closing as many files as it opens so that a backlog does not develop. Each claim should be reviewed on a diary system to ensure that attorneys do not allow cases to remain unnecessarily inactive for unreasonable periods of time. When a claim is closed, the reserves on that claim are eliminated thus reducing total aggregate case reserves.

4. Data Collection Procedure: Performed internally by in-house claims department.

5. Frequency and Time of:
   (a) collecting – annually
   (b) Reporting - annually

6. PCF/Board is responsible for data collection, data accuracy and integrity, data maintenance, and retrieval of integral information.

Note: It should be noted that cooperation from primary insurers continues to be a major obstacle in attaining this goal and is, obviously outside the control of this agency.

E-15

1. Indicator Name: Claims Settled Annually (GOALS III)

2. Indicator Type: Efficiency

3. Rationale: Represents the number of claims resolved by a payment to the claimant not requiring litigation, with its corresponding legal expenses, court costs and judicial interest; an indication of how efficiently the PCF adjusting process is working.

4. Data Collection Procedure: Performed internally by in-house claims department personnel.

5. Frequency and Timing of
   a. collection - daily
   b. reporting – monthly or as needed

6. Calculation Methodology: Any cases involving an indemnity payment that is not the result of a court judgment.

7. PCF/Board is responsible for data collection, data accuracy and integrity, data maintenance, and retrieval of integral information.

E-16

1. Indicator Name: Average Caseload per Adjuster (GOAL III)

2. Indicator Type: Efficiency

3. Rationale: Represents the number of active claim files for which an individual adjuster is responsible. The more files an adjuster is handling, the less time that can be devoted to each file. The quality of the adjusting process (investigation, evaluation and resolution) can sometimes be in direct proportion, either positively or adversely, to an adjuster's caseload.

4. Data Collection Procedure: Performed internally by in-house claims staff.

5. Frequency and Time of:
   (a) Collecting – annually
   (b) Reporting - annually

6. PCF/Board is responsible for data collection, data accuracy and integrity, data maintenance, and retrieval of integral information.

E-17

1. Indicator Name: Annual Number of Claims Closed Without Payment - CWP (GOAL III)

2. Indicator Type: Quality

3. Rationale: Represents the percentage of filed claims that are reserved, investigated, evaluated and resolved without any indemnity payment being made from the PCF. The PCF provides excess coverage, and the fewer claims that reach this excess layer the better. Every claim that is closed without an indemnity payment reduces overall aggregate case reserves.

4. Data Collection Procedure: Performed internally by in-house claims staff.

5. Frequency and Timing of
   (a) collection - daily
   (b) reporting - annually

6. Calculation Methodology: In the absence of any settlement, judgment, or future medical payment, a claim is considered closed without payment. Legal and miscellaneous expenses are not considered in these situations.

7. PCF/Board is responsible for data collection, data accuracy and integrity, data maintenance and retrieval of integral information.